

# Health Equity Data Analytics (HEDA) Stakeholder Outreach Summary of Findings



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## State Agency Data Systems

Department of Housing (DOH)	Department of Mental Health & Addiction Services (DMHAS)	Department of Public Health (DPH)	Department of Social Services (DSS)
<p>Homeless Management Information System (HMIS)</p> <p>HMIS Platform: CaseWorthy</p> <p>HMIS links to DMHAS Data portal (DDAP)</p>	<p>30 homegrown databases</p> <p>No internal interoperability</p> <p>Data use agreements needed between 8 state-operated health facilities</p>	<p>Numerous and disparate state &amp; federal databases</p> <p>Wide range of sharing capacities depending on data sharing agreements</p>	<p>2 primary eligibility systems: IMPACT &amp; HIX</p> <p>Interfaces with external systems, such as federal repositories (DOL)</p>

## Methods

- Conducted exploratory interviews with (n = 7) stakeholders
- Timeline: April 2020 to August 2020
- Format: Telephone interviews gathering information on:
  - Data, systems, storage & privacy
  - Perceived benefits and opportunities
  - Challenges and concerns of participation

## Community-Based Organization Data Systems

Connecticut Community Cares (CCC)	Thames Valley Council for Community Action, Inc. (TVCCA)	Hispanic Health Council (HHC)
<p>Connexus - organizational internal electronic record</p> <p>Data duplicate entry into DSS database systems</p>	<p>2 main in-house databases: Fuelware - energy assistance program database Tribeware - case management program database</p> <p>Additional external program-specific databases: Head Start (ChildPlus), Housing (HMIS)</p> <p>Databridge to DSS</p>	<p>Numerous and disparate internal, state &amp; funder-specific databases across agency</p> <p>Databases include Apricot (electronic record), Microsoft Access, Excel spreadsheets, Ryan White, WIC, Hospitals, Immunizations, SNAP</p> <p>Duplicate data entry into DSS &amp; DPH database systems</p>

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## Potential benefits of Signing onto the HIE

State agencies	Community-based organizations
<ul style="list-style-type: none"> <li>• Elevating existing data with granular race/ethnicity detail to highlight disparities, inform programs and resource distribution.</li> <li>• Improving surveillance and addressing data lag by enabling data to be captured directly from providers.</li> <li>• Enabling data matches with other state agencies and increasing possibility of cross-agency collaborations.</li> <li>• Comparative data analytics across payers.</li> <li>• Matching missing data (e.g. race &amp; ethnicity for surveillance; data needed by provider to optimize delivery of care)</li> </ul>	<ul style="list-style-type: none"> <li>• Enabling real-time data pulls</li> <li>• Preventing duplicate data entry</li> <li>• Facilitating access to state data to develop resources (e.g. for CHWs) and support statewide initiatives</li> <li>• Integrating health information and social service data embedded in other state agencies into programmatic work and organizational processes (e.g. streamlining outreach, integrating CHWs services)</li> </ul>

## Stakeholder Challenges/Barriers to Participating in the HIE

Varying levels of data infrastructure	Limited interoperability
<ul style="list-style-type: none"> <li>• Stakeholders cited multiple antiquated, disparate informatics systems (internal and external) as a major challenge.</li> <li>• CBOs with internally developed databases or electronic records have flexibility to customize or build out data fields. This does not extend to external informatics systems.</li> <li>• Agencies have limited flexibility to alter data bases due to mandates or logistic challenges even when they own the data system.</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholders cited interoperability as an underlying challenge and highly valued an opportunity enhance this capacity.</li> <li>• CBOs bridging internal data systems with external state or programmatic systems are challenged with significant duplicate data entry and related administrative burdens.</li> <li>• Agencies have varying levels of interoperability depending on data infrastructure and legal mandates.</li> </ul>
Legal restrictions	Operational limitations
<ul style="list-style-type: none"> <li>• Stakeholders ability to share data was limited by various restrictions including Federal and state statutes, HIPAA regulations, data use agreements between organizations.</li> <li>• Data security, privacy and client consent were identified as greatest risk to participation.</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholders faced varying levels of SDOH analytical capacity depending on program and outcomes of interest.</li> <li>• Inhibiting factors included nonstandard standards and tools for data collection, lack of staff time and resources to process existing data, and limited access to real-time data.</li> </ul>

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## Desired Technical Assistance

State agencies	Community-based organizations
<p><b>Technical handshake</b> with diverse EMRs and systems to enable receipt of a standard format of data or case report.</p> <p><b>Support for providers</b> working with agencies to sustain adoption and buy-in.</p> <p><b>Legal assistance</b> to navigate various statutory and funding obligations. For example, Opt-in/Opt-out and if specific mental-health opt-in or other accommodations are possible.</p>	<p><b>Increasing analytic capacity:</b> Support with determining how to optimize the data being exchanged and types of analytic capacities possible to support an organization's mission.</p> <p><b>Technical connectivity:</b> expediting adoption of electronic record across organization and configuring interface between state agency or funder-mandated databases.</p>

## Recommendations Informed by Stakeholder Findings:

- CBOs and agencies had varying levels of knowledge and understanding of the HIE.
- Many stakeholders were unable to contemplate their organization's readiness or TA needs.
- **Recommendations:**
  - Invest in education and development of easily digestible and shareable materials.
  - Engage CBOs and state agencies in Opt-in/Opt-out consent education and feedback.
- Data completeness and quality of health equity data elements varied widely across stakeholders.
- **Recommendation:**
  - Support uniform standard of collection of health equity data elements would help to increase quality and future analytic capacity of the HIE.

## Desired SDOH Analytic Capacities

- DSS: Cross-payer examination of equity issues. (e.g. ACE, birth outcomes etc. and areas of the population that are missed when focusing exclusively on Medicaid.)
- DOH: Projections on populations more likely to need housing resources and cross analyzing with cost of resources.
- DMHAS: Analytics that demonstrate the impacting the agency on individuals and populations (e.g. data on factors supporting and impeding recovery including housing, primary care.)
- CCC: Standardized and verifiable tool to capture SDOH. Combining data collected on individual's functional ability or disability with SDOH data for population analytics and individual outreach.
- TVCCA: Easy access granular New London data to support community needs assessments and help shape programming to meet unique needs of their population.

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**Table 1: Summary of race and ethnicity data fields collected from stakeholder outreach**

DPH Minimum standard	DPH Ideal Standard	DSS	DMHAS	HHC
American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White  Hispanic or Latino Not Hispanic or Latino  (OMB 1997)	American Indian or Alaska Native; Specify tribal affiliation: Asian Asian Indian Korean Chinese Taiwanese Filipino Vietnamese Japanese Other Asian; specify: Black or African American Native Hawaiian or Other Pacific Islander White Other race; specify:	White Black or African American American Indian or Alaska Native Hispanic or Latino/a Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian Native Hawaiian Samoan Guamanian or Chamorro Other Pacific Islander	American Indian/Native Alaskan Asian Black/African American Native Hawaiian/Other Pacific Islander White/Caucasian Other Unknown	White (European, Middle Eastern, Arab, North African) Black/African American (African, African American, Haitian, Jamaican, Dominican, West Indian) American Indian/Alaskan Native Asian (Chinese, Vietnamese, Cambodian, Asian Indian, other) Native Hawaiian/Other Pacific Islander Other:
<b>DOH</b>				
OMB 1997 + Client Doesn't Know Client Refused Data Not Collected	Hispanic or Latino Cuban Mexican Puerto Rican South or Central American Other Hispanic/Latin culture or origin, regardless of race; specify: Not Hispanic or Latino	Mexican Mexican-American Chicano/a Cuban Puerto Rican Other Hispanic, Latino/a or Spanish  *Renewal of Eligibility form	Hispanic-Other Non-Hispanic Hispanic-Puerto Rican Hispanic-Mexican Hispanic-Cuban Unknown	Puerto Rican Mexican Cuban Dominican Central American (Salvadorian, Honduran, Guatemalan, other) South American (Colombian, Ecuadorian, Peruvian, other) Other Hispanic/Latino:  *Breastfeeding Heritage & Pride program intake

**Table 2: Summary of insurance data fields collected from stakeholder outreach**

DMHAS	DOH	DPH	TVCCA	HHC
No health insurance Other private insurance Medicare Champus Medicaid Husky C HMO (including Managed Medicaid) GA-SAGA ATR-Access to Recovery Self Pay Medicaid LIA Husky D Medicare Part A Medicare Part B Money Follows The Person (MFP) Nursing Home Waiver Medicaid BHH Medicaid- Husky A Medicaid BHH - Waiver Other Unknown	Yes No Client Doesn't Know Client Refused  *(Statewide Coordinated Access Network Intake)	Not included in either minimum or ideal standard sociodemographic data collection	Direct purchase Employment Military Medicaid Medicare CHIP State insurance adult, None Unknown Unreported	Program dependent.  *Breastfeeding Heritage & Pride program intake does not collect